Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Hamilton Co Hospital District

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-15-1567-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
January 27, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $605.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the documentation from Hamilton County Hospital District does not meet the criteria of the above definition."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 8, 2014	Outpatient Hospital Services	$605.25	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines an emergency
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 899 – Documentation and file review does not support an emergency in accordance with Rule 133.2

Issues

1. Did the requestor support the services meet the definition of an emergency as defined by Rule 133.2?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as 899 – "Documentation and file review does not support and emergency in accordance with Rule 133.2." 28 Texas Labor Code §133.2 (5) states in pertinent part,

"Emergency--Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part; " Review of the medical record finds;

a. Physician documentation, "Context: The problem was sustained outdoors, resulted from A got hit him in the right knee approximately 2 weeks ago with it's horn. He has had pain and discomfort and swelling since…"

The Division finds the documentation does not support, "sudden onset" as required by Rule 133.2. The carrier's denial is supported.

2. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		March , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.